Memorial University of Newfoundland

HEALTH STATEMENT and MEDICAL RELEASE for Travel

Event/Program: ____

Participant Name______________________________ Birth date ___ /___ /___ Age _____ Gender M / F

Email ______________________________ Student # ______________________________

Home Phone ______________________________ Address ______________________________

Work Phone ______________________________ City ______________________________Prov.__________

Cell Phone ______________________________ Country ____________________ Postal Code _____________

In an emergency, notify: ______________________	Relationship: ______________________________
Home Phone ______________________________	Address ______________________________
Cell Phone ______________________________	City ___________________________ Prov.______________
Work Phone ______________________________	Postal Code _________ Email: ____________________

Health History

Please list or identify any physical or medical conditions or medications you are taking that might impact on your ability to participate in or create a hazard to you while participating in this Event/Program. If you provide this information, it will be used to assist or provide assistance to you if an injury or life threatening situation should occur during your participation in the Event/Program.

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All information requested on this form will be used solely for the administration and management of the Event/Program and is only collected for purposes related to your health and safety and in relation to the provision of your medical care. It will be used for no other purpose and will not be disclosed unless required by law. Personal information is collected under the general authority of the Memorial University Act (RSNL 1990 Chapter M-7). Questions about this collection and use of personal information may be directed to the Risk and Insurance Services.

(REV: APR. 2014)

Representation, Consent, and Emergency Authorization

1. **Health History Attestation**
   This Health History set out in this form is true and accurate so far as I know and believe, and that my health is satisfactory to participate in the Event/Program.

2. **Permission and Consent – Emergency Medical Treatment**
   In the event that an accident or illness renders me unable to communicate directions for medical treatment:

   (Choose One)

   - ☐ I hereby consent and give my permission to Memorial University of Newfoundland and the medical personnel selected by them to render such emergency medical diagnosis and treatment as is deemed necessary, including but not limited to X-ray examination, injection, anesthesia, and/or surgery for me. Such authorization for emergency treatment shall also include, but not be limited to, costs incurred for the provision of such aid, treatment, and arranging evacuation if it is determined that such evacuation is medically necessary and desirable. I further agree and will assume financial responsibility for the cost of any specialized means of evacuation and the necessary medical care. I understand and acknowledge that these costs are my responsibility.

   - ☐ I have stated my directions for medical treatment in the attached Advance Health Care Directive dated ____________________________, which has been made by me in accordance with *the Advance Health Care Directives Act*, SNL 1995 c.A-4.1. I understand that all costs incurred for the provision of such emergency medical diagnosis and treatment as is deemed necessary is my financial responsibility. Such treatment may include, but is not limited to, x-ray examination, injection, anesthesia, and/or surgery and arranging evacuation if it is determined that such evacuation is medically necessary and desirable.

3. **Emergency Notification**
   I hereby consent and give my permission to Memorial University of Newfoundland to contact the individual(s) which I have listed in the emergency notification section of this form in the case of an emergency.

Participant __________________________ (printed) _________________________ Date ___________________

PARENT/GUARDIAN/CUSTODIAN MUST READ THIS FORM AND SIGN BELOW
(IF PARTICIPANT IS UNDER 19 YEARS OF AGE)

This is to certify that I/we, as parent(s)/guardian(s) with legal responsibility for this participant, do consent to the foregoing and agree that all costs incurred for the provision of such emergency medical diagnosis and treatment as is deemed necessary is my/our financial responsibility. Such treatment may include but is not limited to, x-ray examination, injection, anesthesia, and/or surgery and arranging evacuation if it is determined that such evacuation is medically necessary and desirable.

Parent/Legal Guardian ____________________ (printed) ________________________ Date____________________

Parent/Legal Guardian_____________________ (printed) ________________________ Date____________________

Address ________________________________ City ____________________ Prov. ____ Postal Code___________

Home phone ___________________ Work phone ____________________ Email __________________________

Witness Signature_________________________(printed)________________________ Date____________________